How to Complete and File Health Screening Benefit Claims

Please use this form to submit Group Critical Illness and/or Group Hospital Indemnity Health Screening Benefit claims following the instructions below. We will evaluate your claim based on the terms and conditions of your insurance coverage. If we need additional information or documentation, we will contact you.

There is a 30 day waiting period before this benefit can be paid. If you have questions, call us toll-free at 1-844-863-1020 or send an email to BenefitsClaims@LibertyMutual.com.

1. Carefully read the applicable fraud warning notice on pages 2-3.

2. Have the patient read and sign the authorization on pages 4-5. If you are an authorized representative, include a copy of the legal document(s) authorizing you to act on the patient’s behalf.

3. Complete Parts I-III on page 6.

Include completed and signed claim forms for each patient.

4. Complete Part IV on page 7.

Have the patient’s attending physician complete and sign this form, and attach it to your claim form, or attach a copy of itemized physician, clinic or facility receipt, showing preventative services or tests performed with CPT codes and dates of service.

5. Submit your completed form and required documentation by mail or email:

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| **Mail:** Liberty Life Assurance Company of Boston 100 Liberty Way Mailstop 01-4 Dover, NH 03820 | **Email:** BenefitsClaims@LibertyMutual.com |

**The acceptance of a claim form by an insurance company is not an admission of coverage, nor does it recognize the validity of any claim.**

FRAUD WARNING NOTICE

* **For states not listed below**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
* **For residents of Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
* **For residents of Arizona:** For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
* **For residents of Arkansas, Louisiana, Rhode Island and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
* **For residents of Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
* **For residents of California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
* **For residents of Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
* **For residents of Delaware and Idaho: WARNING:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony.
* **For residents of the District of Columbia: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.
* **For residents of Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
* **For residents of Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.
* **For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
* **For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
* **For residents of Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
* **For residents of Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
* **For residents of New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

FRAUD WARNING NOTICE (continued)

* **For residents of New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. §638:20.
* **FOR RESIDENTS OF NEW MEXICO:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
* **For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.
* **For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
* **For residents of Oklahoma:** **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
* **For residents of Oregon:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance may be guilty of a crime, and may be subject to fines and confinement in prison.
* **For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
* **For residents of Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



**Liberty Life Assurance Company of Boston**

**100 Liberty Way. 1-844-863-1020**

**Mailstop 01-4** **BenefitsClaims@LibertyMutual.com**

**Dover, NH 03820**

AUTHORIZATION FOR THE RELEASE OF INFORMATION, INCLUDING PROTECTED
HEALTH INFORMATION

I hereby authorize the use or disclosure of information about me as described below:

1. Person(s) or group(s) of persons authorized to use or disclose the information:

Any physicians, medical practitioners, hospitals, clinics, HMOs, long-term care facilities, medical or medically-related facilities, insurance companies, current or former employers, MIB, Inc., and insurance support organizations.

1. Person(s) or group(s) of persons authorized to collect or otherwise receive the information:

The particular company in the Liberty Mutual Group of companies to which I am submitting a claim and its authorized representatives, agents and/or employees and other organizations providing claims management services.

1. Description of the information that may be used or disclosed:

This authorization specifically includes the release of all information related to:

* My physical and mental health and my insurance policies and claims, including but not limited to those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding communicable or infectious conditions, including HIV/AIDS.
* Personnel records and other work-related information.
1. Information will be used or disclosed only for the following purpose(s):

For investigating, evaluating and processing my claim, and/or for insurance-related functions.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

* **I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure as necessary by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.**
* I understand that I may revoke this authorization in writing at any time by sending a written revocation to the company in the Liberty Mutual Group of companies to which I have submitted a claim, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides the company with the right to contest a claim. I also understand that revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and health care operations.
* I understand that authorizing the disclosure of my health information is voluntary and the provision of health care services to me is not conditioned on whether I sign this authorization. If I choose not to sign this authorization, insurance coverage or claim payments may be denied or delayed.
* This authorization shall remain in force for 24 months from the date of signing, except to the extent applicable state law imposes or allows a different duration. The information obtained under this authorization will be retained in accordance with the company’s standard retention policy and applicable law.
* I understand that I may request a copy of this authorization.

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|       |  |       |
| Printed name of individual/authorized representative  |  | **Date** |
|       |  |       |
| **Signature** |  | **Date**  |
|  |  |  |
| Description of authority of authorized representative:      |
| Date of birth:      | Claim number:      |
| Street address:      |
| City:       | State:       | ZIP code:       |

A copy of this authorization will be considered as valid as the original.



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**100 Liberty Way. 1-844-863-1020**

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**Dover, NH 03820**

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| **Part I: Employee information** |
| **Employee name** (Last, First Middle Initial)**:**       | **SSN:**       |
| **Address** (Street, City, State, Zip Code)**:**       |
| **Home phone:**       | **Work phone:**       | **Cell phone:**       |
| **Email address:**       | **Date of birth:**       |
| **Occupation:**       | **Gender:**  **[ ]** Male [ ]  Female |
| **Employer’s name:**       | **Certificate Number:**       |
| **Part II: Patient information**  |
| **Patient:** **[ ]  Employee** (If you check this box, skip to Part III) **[ ]  Spouse [ ]  Dependent Child** |
| **Patient name** (Last, First, Middle Initial)**:**       | **SSN:**       |
| **Address** (Street, City, State, Zip Code)**:**       |
| **Home phone:**       | **Work phone:**       | **Cell phone:**       |
| **Email address:**       | **Date of birth:**       |
| **Gender:**  **[ ]** Male [ ]  Female |  |
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| **Part III: claim details**  |
| **Have your physician complete and sign part IV on page 7, or attach an itemized physician, clinic or facility receipt – showing the preventative service or test performed with CPT codes and date of service – to this form.** |

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| The above statements are true to the best of my knowledge and belief, and I have read the applicable fraud warning notice on pages 2-3.**For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. |  |  |

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|       |  |       |
| **Printed name of employee or authorized representative**  |  | **If signed by authorized representative, describe legal relationship.** |
|       |  |       |
| **Signature of employee or authorized representative** |  | **Date** |

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| **Part IV: Attending physician statement** |
| **Patient name** (Last, First, Middle Initial)**:**       |
| **Patient’s date of birth:**       | **Date of service:**       |
| **Please check all preventative services provided to this patient:** |
| **[ ]** Biopsies for cancer[ ]  Blood test to determine total cholesterol[ ]  Blood test for triglycerides [ ]  Bone marrow testing[ ]  Breast MRI[ ]  Breast ultrasound[ ]  Breast sonogram[ ]  Cancer antigen 15-3 blood test for breast cancer (CA 15-3) [ ]  Cancer antigen 125 blood test for ovarian cancer (CA 125)[ ]  Carcinoembryonic antigen blood test for colon cancer (CEA)[ ]  Carotid Doppler[ ]  Chest X-ray[ ]  Clinical testicular exam[ ]  Colonoscopy[ ]  Digital rectal exam (DRE)[ ]  Doppler screening for cancer[ ]  Doppler screening for peripheral vascular disease[ ]  Echocardiogram[ ]  Electrocardiogram (EKG)[ ]  Endoscopy[ ]  Fasting blood glucose test[ ]  Fasting plasma glucose test | [ ]  Flexible sigmoidoscopy[ ]  Hemoccult stool analysis[ ]  Hemoglobin A1C[ ]  Human papillomavirus (HPV) [ ]  Lipid panel[ ]  Mammography[ ]  Oral cancer screening[ ]  Pap smear or thin prep Pap test [ ]  Prostate-specific antigen test (PSA)[ ]  Serum protein electrophoresis (blood test for myeloma) [ ]  Skin cancer biopsy[ ]  Skin cancer screening[ ]  Skin exam[ ]  Stress test on bicycle or treadmill[ ]  Tests for sexually transmitted infections [ ]  Thermography[ ]  Two-hour post-load plasma glucose test[ ]  Ultrasounds for cancer detection[ ]  Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms[ ]  Virtual colonoscopy |
| **Attending physician name** (Last, First, Middle Initial)**:**       |
| **Specialty:**       | **Phone number:**       |
| **Address** (Street, City, State, Zip Code**):**       |
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| **The above statements are true to the best of my knowledge and belief, and I have read the applicable fraud warning notice on pages 2-3:** |
|       |  |       |
| **Signature** |  | **Date** |